County of Los Angeles
CHIEF EXECUTIVE OFFICE
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WILLIAM T FUJIOKA
Chief Executive Officer

January 7, 2010

To: Supervisor Gloria Molina, Chair
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslasky
Supervisor Don Knabe
Supervisor Michael D. Antonovich

From: William T Fujioka
Chief Executive Officer

READINESS FOR H1N1 SURGE SCENARIO (AGENDA OF JANUARY 12, 2010)

On November 17, 2009, your Board instructed this Office, with the Directors of Public Health, Health Services, other affected Department Heads and other appropriate individuals, to provide an extended and specific briefing to the Board within no more than two weeks on the County's plan to deal with a worst-case H1N1 infection surge scenario. On December 1, 2009, your Board continued this item to January 12, 2010.

It should be noted that your Board also requested this Office to provide monthly written updates on the County efforts to pursue federal and State resources needed to prepare and respond to the seasonal and H1N1 influenza. This request is being addressed separately.

SUMMARY

An overview on the progression of the virus from its emergence in the spring of 2009 to today, both nationally and locally, is provided in Attachment I. There have been two distinct waves of this flu so far, and there is a possibility of a third wave this winter. While public officials were initially gravely concerned about the potential impact of the pandemic based on early cases in Mexico, H1N1 has proven to be milder than most typical seasonal flu. However, there is always the potential for the virus to mutate into a more virulent form.

While the County continues to prepare for disaster response through planning, training and exercise, it is recognized that much of the response and recovery, particularly for medical response rests with the private sector, including hospitals and ambulance

providers. There is concern that hospitals are under enormous financial and operational pressures. With competing priorities, disaster preparedness is often given limited attention. Funding from federal grants, such as the Hospital Preparedness Program (HPP) are crucial in the development of the Disaster Resources Center (DRC) program, planning, training, and exercises. There is concern that federal funding for disaster preparedness has continued to decline since 2002. Without funding, preparedness activities will all but disappear. In fact, additional funding would allow for the development of training and exercise programs for low frequency events such as nuclear or biological disasters.

For the Department of Health Services/Emergency Medical Services Agency (DHS/EMS), which coordinates 911 response, lack of a timely and robust patient tracking system is of concern. The DHS/EMS has been working with some 911 providers and minimal grant funding to develop electronic patient tracking systems. This program is at the very early stages and will require funding and support.

Attachment II is a report on the H1N1 Influenza Surge Planning efforts and the Department of Public Health (DPH). Further, we have included the following information regarding:

- County Disaster Authority;
- Emergency Trauma and Mass Casualty Coordination;
- Resource Request; and
- Departmental Roles.

COUNTY DISASTER AUTHORITY

Disaster response and authority for Los Angeles County is defined in Chapter 2.68 EMERGENCY SERVICES of the County code. The Sheriff, as the Director of Emergency Operations is responsible for the coordination of all emergency operations during a disaster. Chapter 2.68 charges the Office of Emergency Management (OEM) with the responsibility for organizing and directing the preparedness efforts of the Emergency Management Organization of Los Angeles County. OEM is the day-to-day Los Angeles County Operational Area Coordinator for the geographic area of the County. Powers and responsibilities for each County department and cities are further defined in the Los Angeles County Operational Area Emergency Response Plan (LACOAERP), approved in 1998. Health-related responses are divided between DHS/EMS, which has responsibility for emergency, trauma, and mass casualty incidents, and DPH which has responsibility for community health implications of incidents.

EMERGENCY TRAUMA AND MASS CASUALTY COORDINATION

During a disaster the LACOAERP designates the Director of DHS as the Operational Area Coordinator for the county-wide management and allocation of medical and health resources, both public and private. The Director of DHS may designate hospitals, clinics, and skilled nursing facilities as casualty collection points to handle mass casualties. In addition, Section 1797.152 of the Health and Safety Code defines the appointment of the Regional Disaster Medical/Health Coordinator (RDMHC) to coordinate the intra-regional medical and health mutual aid response in the event of a disaster. The Director of the DHS/EMS has been appointed to this position by the State EMS Authority and California Department of Public Health (CDPH).

Since 2002, as part of the federally funded HPP and Public Health Emergency Preparedness Program (PHEP), DHS and DPH have established a system for medical and health disaster preparedness and response that are built upon common plans coordinated to deliver effective care. Key elements include the following:

- DRC Program, which designates certain hospitals to coordinate preparedness activities with the surrounding healthcare providers;
- Stockpile of key resources;
- Mobile Assets, including the Mobile Medical System (MoMS) formerly known as the "mobile hospital;"
- Planning and Training; and
- Advanced laboratory analysis.

The roles of the system participants are intertwined and overlap. In the event of a disaster, hospitals implement their emergency plans on an individual facility level and as the impact heightens and/or needs emerge, these hospitals collaborate with the County through DHS and DPH for additional assistance. This may include using the mutual aid provision of the HPP agreements that the County has with the 83 participating HPP hospitals. Issues outside the authority of the County are addressed by CDPH and the Emergency Medical Services Authority (EMSA) (Attachment III).

RESOURCE REQUEST

The flow of information and how resource requests are handled is a process that is similar in any type of emergency. It starts at the individual hospital level and escalates as unmet needs are identified, going from the local, to the Operational Area, the Regional level, the State, and finally to the federal level. However, in a worst-case scenario for H1N1 influenza or any other disaster situation everyone and every level would be impacted, therefore, the key activities would focus on communication and

coordination, distributing available resources and working with the State to address flexibility in hospital space use and staffing (Attachment IV).

DEPARTMENTAL ROLES

DHS Role - In a worst-case scenario for H1N1 influenza or any other disaster situation, DHS would activate its Department Operations Center (DOC) with dedicated staff assigned to monitor the situation, identify needs, and work collaboratively with individual hospitals, the Hospital Association of Southern California, DPH and provider agencies to implement actions to address the needs. DHS' DOC would work with the hospitals and CDPH licensing to expand patient care areas, which may include the use of propositioned tent structures or non-traditional patient care areas within the hospitals to support the surge of patients and if needed, MoMS may be deployed to expand the surge capacity of one hospital. Volunteer staff would be requested using the Emergency System for the Advanced Registration of Volunteer Health Professionals (ESAR VHP) and key resources from established stockpiles would be deployed to the hospitals and other healthcare partners. Dispatch protocols for 911 calls would be implemented allowing patients to be evaluated and not transported, when they meet established criteria.

Like other hospitals, DHS hospitals and their associated networks have response plans which have recently been updated and include consideration of pandemic flu scenarios. DHS has also developed a system-wide Flu Task Force, which is charged with identifying and implementing evidence-based best practices that will serve to mitigate against a potentially severe flu season. These activities were described further in DHS' November 3, 2009 report to your Board (Attachment V).

DPH Role - In the event that H1N1 became more deadly, or in any other community-wide emergency, DPH's primary role and responsibility is to recommend measures to contain the pathogen and prevent the spread of disease throughout the community.

DPH would activate its DOC and provide guidance related to clinical care and procedures, such as what type of diagnostic testing is needed, which patients should be treated with antiviral medications, and the distribution of appropriate countermeasures.

Given the wide range of public health threats—natural disasters, biological, radiological and nuclear events—DPH response activities are tailored to the specific incident and include: provision of relevant clinical guidance, rapid laboratory confirmatory testing, coordination of pharmaceutical interventions such as vaccine and antivirals, distribution of personal protective equipment and other medical supplies to hospitals and other treatment centers from the federal Strategic National Stockpile and educating the public.

If and when these interventions are not adequate to address the surge in demand for medical and/or hospital services, DPH will coordinate public messaging in conjunction with DHS and OEM to minimize unnecessary demand on the medical care system.

CONCLUSION

Collaboration between DPH, DHS/EMS, and public and private hospitals, including work done over the past seven years under the HPP, has refined the medical response system. Communication and collaboration have improved, plans have been developed, and stockpiles of needed assets have been established. These plans and resources will be utilized to the extent necessary to respond to a worse-case H1N1 scenario.

If you have any questions please contact me, or your staff may contact Cathy Chidester, Department of Health Services, at (562) 347-1604 or at cchidester@dhs.lacounty.gov, Alonzo Plough, Department of Public Health, at (213) 637-3600 or at aplough@ph.lacounty.gov, or Richard F. Martinez at (213) 974-1758 or at rmartinez@ceo.lacounty.gov.

WTF:SAS
MLM:RFM:gl

Attachments (5)

c: Executive Office, Board of Supervisors
County Counsel
Department of Health Services
Department of Public Health

010710_HMHS_MBS_Readiness for H1N1 Surge Scenario

Attachment I

OVERVIEW – H1N1 PANDEMIC

On April 26, 2009, the then Acting Secretary of Health and Human Services declared a public health emergency following the detection of 20 cases of novel swine-origin influenza A virus in the United States. On June 11, 2009, the World Health Organization (WHO) declared the first pandemic in over 40 years as a result of widespread, sustained human-to-human transmission of this virus in more than 70 countries around the world. As of November 2009, worldwide more than 207 countries and overseas territories or communities have reported laboratory confirmed cases of pandemic influenza H1N1 2009, including at least 8,768 deaths. This is most likely a large underestimate, as many countries have stopped counting individual cases, particularly of milder illness.

In the United States, influenza virus circulation remains active and geographically widespread, however, disease activity appears to have peaked in past 3 to 4 weeks. Deaths due to pneumonia and influenza (P&I mortality) continued to increase past the epidemic threshold for the past 8 weeks and cumulative rates of hospitalizations for the current influenza season have exceeded rates seen in recent seasons among all age groups except those aged ≥ 65. As of November 28, 2009, the CDC reported 31,320 hospitalizations and 1,336 deaths defined by influenza laboratory tests. Figure 1 shows the percentage of emergency room (ED) visits for influenza-like illness (ILI) for the week ending on November 28.

In Los Angeles County, we experienced the first wave in the spring, and cases remained over the summer with elevated levels of flu. In fact, there were periodic outbreaks of flu associated with local summer camps. Cases steadily increased from early September through mid-November in what seems to have been our second wave. Figure 2 shows the percentage of ED visits for ILI for ages 5-14 through November 28 for Los Angeles County. Since that time, we have seen a dramatic drop in cases. The Department's ED surveillance system for all ages also shows that we are still experiencing higher than normal cases for the season (Figure 3). We also continue to have periodic geographic outbreaks.

From April to December 4, 2009, there have been 284 ICU admissions due to confirmed pandemic influenza A type H1N1 in Los Angeles County. Of these cases 97 have been deaths. The number of ICU/deaths seems to have peaked during the last week in October. Los Angeles County Department of Public Health (DPH) continues to receive many reports of ICU admissions and deaths due to H1N1. However, the number of hospitalizations due to any influenza as well as the rate (per 1,000 hospital beds) of laboratory confirmed influenza continues to decrease.

Figure 1: Percentage of ED visits for Influenza-like Illness (ILI) for week ending 11/28/09

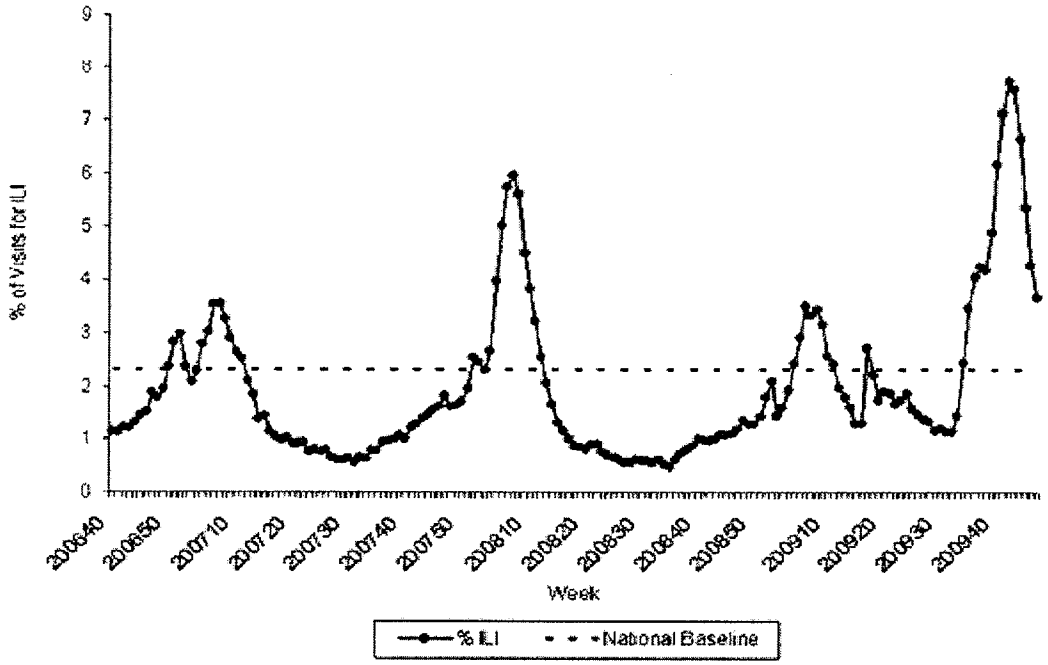


Figure 2: Percent of ED visits for ILI, Ages 5-14, week ending 11/28/09

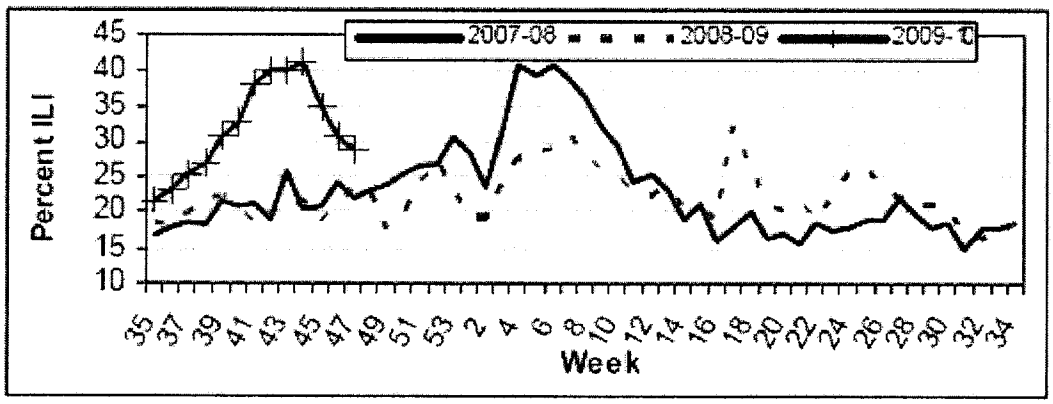
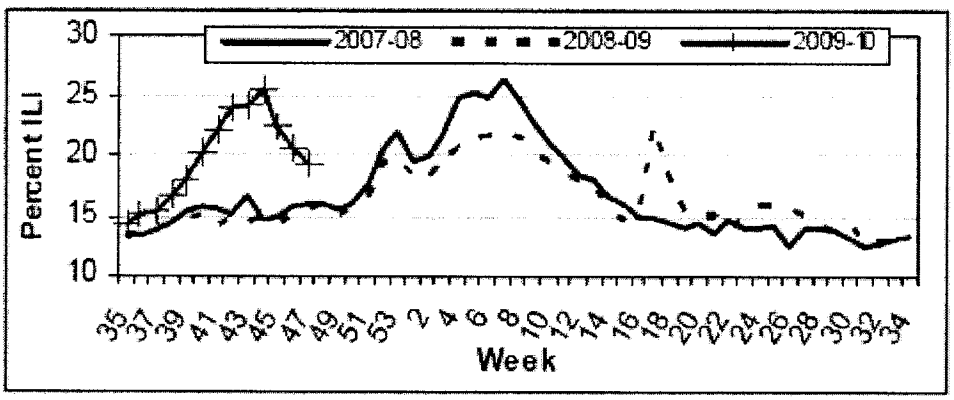


Figure 3: Percent of ED Visits for ILI, All Ages, week ending 11/28/09



H1N1 INFLUENZA SURGE PLANNING

Overview of Preparedness Activities

The Department of Health Services (DHS), through the Emergency Medical Services (EMS) Agency serves as the medical coordinator during disasters. In this role, DHS is responsible for organizing, mobilizing, coordinating and directing medical services in Los Angeles County, both public and private. The activities focus on coordination with provider agencies in determining and supporting patient destination and transportation from the field, and providing resources and support to hospitals to ensure they remain operational and are able to expand capacity for the surge of patients.

In 2002, DHS became a direct recipient of the Hospital Preparedness Program (HPP) federal grant. The goal of the HPP is to ready hospitals and supporting health care systems to deliver coordinated and effective care to victims of disasters including natural and man-made events.

The initial focus of the HPP was on terrorism events. In 2004 it broadened to "All-Hazards," and in 2006 a focus on Pandemic Influenza was added.

In 2003, the second year of the HPP, the County developed and implemented the Disaster Resource Center (DRC) Program. The DRC concept was developed to address issues related to surge capacity.

Outcomes associated with this program include the following:

- Enhance surge capacity for hospitals through the provision of ventilators (a total of 300 have been purchased by the DRCs), pharmaceuticals, medical/surgical supplies including surgical and N95 masks and large tent shelters with negative pressure capability to provide treatment to victims of a public health emergency.

- Enhance hospital planning and cooperation in a geographical area to include planning regarding surge capacity. This planning addresses the use of non-hospital space to shelter and treat mass casualties, including the role of local community health centers and clinics.

Thirteen hospitals are designated as DRCs serving 10 geographical regions (see map on Attachment II-A). Each DRC has eight to ten "umbrella" hospitals assigned to it to work with, as well as clinics and EMS Provider Agencies from the area. Each DRC developed a Regional Response Plan that addresses general surge activities with consideration for the uniqueness of each region.

Pandemic Specific Preparedness Activities

Hospitals

In 2005, HPP participating hospitals were required to develop and/or incorporate a Pandemic Influenza plan into the hospital's overall emergency management plan. Hospitals (74) have developed pandemic influenza plans addressing the following:

- Surveillance
- Respiratory Hygiene
- Triage
- Surge capacity
- Staffing
- Admission Tracking
- Isolation and use of Personal Protective Equipment
- Vaccination and medical treatment
- Mortuary services
- Staff and public education
- Communication

To assist hospitals in their planning, in June 2007, a guidance document entitled, *Recommended Actions to Prepare Hospitals for Pandemic Influenza by Pandemic Phase* was annexed to the DRC Regional Response Plan. The EMS Agency is currently working to update this document based on the experience gained in dealing with the 2009 H1N1 influenza.

In 2006, the California Department of Public Health (CDPH) utilized CDC's FluSurge 2.0 modeling software to calculate the number of surge beds that would be needed during a pandemic with moderate surge on a statewide basis. This scenario would be much worse than what we have experienced to date with H1N1. The model predicted that California would need 58,723 beds. Through healthcare facility expansion and Government-Authorized Alternate Care Sites (non-traditional sites such as sports arenas, etc.) the statewide identification of surge beds now totals 66,031. On a countywide basis the identified need is 16,109 surge beds with 13,599 surge beds identified.

Expanding hospital capacity (creating surge) includes freeing up inpatient beds through early discharge, cancellation of elective surgeries and procedures and use of licensed beds that are not staffed on a day to day basis. These measures can provide anywhere from a 15 to 20 percent increase in capacity. Other measures to expand capacity include the use of non-licensed beds such as recovery room space and other outpatient space for inpatient care. Hospital plans also address further facility expansion through the use of non-patient care areas such as conversion of conference rooms. Additionally, all DRCs and Trauma Centers (17 hospitals) have tent shelters that can be set up on their

properties to be used for triage, screening and temporary holding of patients when approved by California Department of Public Health (CDPH) Licensing. DHS continues to use these strategies to work with hospitals to identify additional capacity for disasters. In addition, in a worst-case scenario, LAC could transfer patients outside of the County to utilize some of the additional surge beds identified statewide.

In July 2009, through the HPP, the County received Pandemic Influenza supplemental funding. This funding will be used to cover and/or off-set costs associated with influenza vaccine administration and tracking, training activities related to personal protective equipment and isolation practices used in a pandemic, and to purchase tent shelters, cots and other supplies to support healthcare facility expansion on the hospital campus. All 83 HPP participating hospitals will receive funding to support these activities.

DHS hospitals established a Pandemic Influenza Task Force to review existing hospital plans and to work together on addressing the key issues in responding to a pandemic. This task force is chaired by Dr. Robert Splawn, DHS' Chief Medical Officer and has been meeting on a weekly basis.

DHS/EMS Agency and Public Health

DHS and DPH have also partnered on the following preparedness activities:

Distributed over 1 million surgical and N95 masks to hospitals, clinics and EMS provider agencies and continue to fill requests as needed.

Distributed antiviral medication (Tamiflu) to hospitals and clinics.

Maintain stockpiles of key resources needed for pandemic response to include the following:

- Antiviral medications – over 300,000 courses
- N95 masks – over 900,000
- Surgical masks – over 1.5 million
- Ventilators – 113 vendor managed stockpile

DPH's Health Facilities Inspection Division (HFID) is working with CDPH Licensing and Certification to ensure a statewide approach to the process for hospitals to set up and use tent shelters. CDPH sent an All Facilities Letter (AFL) 09-39 to hospitals on October 30, 2009 to clarify the requirements (Attachment II-B) for this process.

In preparing for a pandemic, DPH and the EMS Agency partnered with the healthcare community conducting multiple workshops and table top exercises.

The EMS Agency is accessible 24 hours a day, 7 days a week through the Medical Alert Center. This is unique to Los Angeles County and its partner hospitals and EMS providers know how to notify the EMS Agency when emergency issues arise so that the EMS Agency can rapidly respond.

Mobile Medical System (formerly called the Mobile Hospital)

In 2007, DHS/EMS Agency purchased a Mobile Medical System (MoMS) as another component in addressing surge. The MoMS is comprised of a trailer facility that expands to a 1000 square foot facility that can be used for initial triage, examination and treatment of patients and four 25 bed tent structures that can be used to provide medical surgical or palliative levels of care.

The primary scenario for use of the MoMS would be an earthquake where the system could be used as a replacement facility and the damaged hospital's personnel and medical staff would staff the MoMS. In a pandemic, the MoMS would be set-up at one hospital, most likely at a County operated hospital and provide surge for that site as needed.

To address staffing, the EMS Agency manages the Los Angeles County Emergency System for the Advanced Registration of Volunteer Health Personnel (ESAR VHP). This registry is part of the State's Disaster Health Volunteer system. There are over 2,250 volunteers currently registered. Volunteers would be asked to staff the MoMS, when needed.

<u>EMS Provider Agencies (Fire Departments and Ambulance Companies)</u>

In 2005, a Provider Agency Pandemic Influenza Task Force was established. The task force developed a guidance document entitled, *Recommended Actions to Prepare EMS Providers for Pandemic Influenza by Pandemic Phase* in March 2007.

With the emergence of the 2009 H1N1 influenza in the Spring of 2009, the EMS Agency established a web site link to communicate key H1N1 information with the EMS community.

In July 2009, the Provider Agency Pandemic Influenza Task Force was re-convened to look at lessons learned from the Spring response. Activities addressed by this task force include the following:

- Distribution of masks
- Addition of vaccination to the paramedic scope of practice
- Approval of vaccination and distribution of H1N1 vaccine to EMS provider agencies
- Dispatch protocols
- Triggers for service changes to include dispatch and staffing levels

- Revision of guidance document to reflect triggers

Hospital Association of Southern California (HASC)

HASC has worked collaboratively with the EMS Agency and Public Health to address issues and concerns of member hospitals. Activities include:

- Updated White Paper on Seasonal Surge events. Hospitals use this document as guidance to handle seasonal influenza and patient surges.
- Provides direct assistance to hospitals related to H1N1 planning.
- Developed H1N1 and seasonal influenza preparedness checklists for hospitals
- Working with California. Hospital Association and supporting its efforts to get clarity from CDPH Licensing and Certification division on the process and requirements for healthcare facility expansion, including the use of tent shelters.

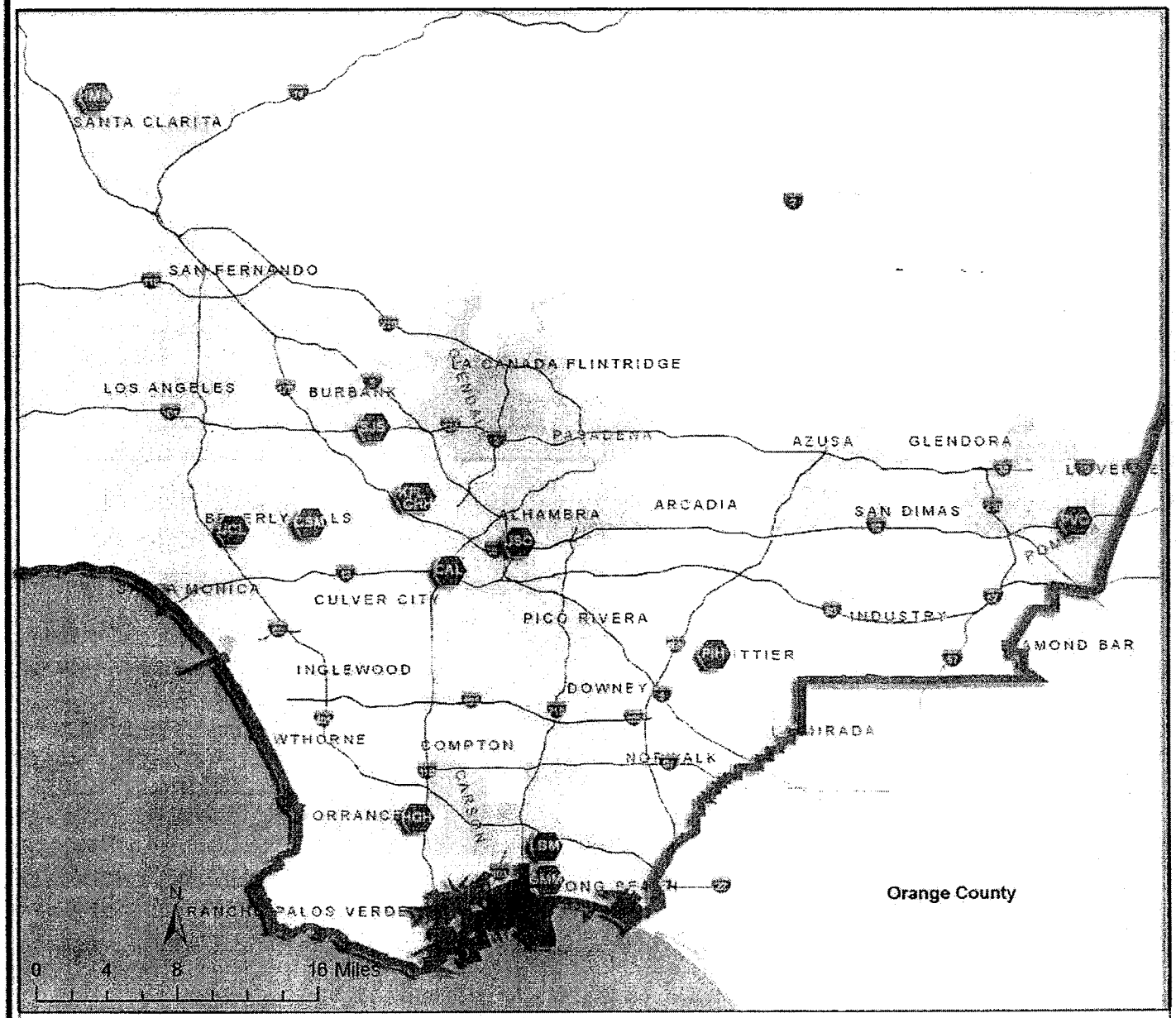
Conclusion

Collaboration between DPH, DHS/EMS, and public and private hospitals, including work done over the past seven years under the HPP, has refined the medical response system. Communication and collaboration have improved, plans have been developed, and stockpiles of needed assets have been established. These plans and resources will be utilized to the extent necessary to respond to a worst-case H1N1 scenario.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **DISASTER RESOURCE CENTERS IN LOS ANGELES COUNTY**

REFERENCE NO. 1102.1



Disaster Resource Center (has decontamination capability)

Code	Hosp_Name	Address	City	Zip
CAL	California Hospital Medical Center	1401 S. Grand Avenue	Los Angeles	90015
CHH	Childrens Hospital Los Angeles	4650 W. Sunset Boulevard	Los Angeles	90027-6062
CSM	Cedars Sinai Medical Center	8700 Beverly Boulevard	Los Angeles	90048-1865
HGH	LAC Harbor-UCLA Medical Center	1000 W. Carson Street	Torrance	90502-2004
HMN	Henry Mayo Newhall Memorial Hospital	23845 W. McBean Parkway	Valencia	91355-2083
KFL	Kaiser Foundation - Sunset (Los Angeles)	4950 W. Sunset Boulevard	Los Angeles	90027
LBM	Long Beach Memorial Medical Center	2801 Atlantic Avenue	Long Beach	90806-1737
PIH	Presbyterian Intercommunity Hospital	12401 E. Washington Boulevard	Whittier	90602
PVC	Pomona Valley Hospital Medical Center	1798 N. Garey Avenue	Pomona	91767
SJS	Providence Saint Joseph Medical Center	501 S. Buena Vista Street	Burbank	91505
SMM	St. Mary Medical Center	1050 Linden Avenue	Long Beach	90813-3393
UCL	Ronald Reagan UCLA Medical Center	757 Westwood Plaza	Los Angeles	90095
USC	LAC+USC Medical Center	1200 N. State Street GH Rm 1112	Los Angeles	90033-1083

EMERGENCY MEDICAL SERVICES AGENCY

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State of California—Health and Human Services Agency
California Department of Public Health

MARK B HORTON, MD, MSPH
Director

ARNOLD SCHWARZENEGGER
Governor

October 30, 2009

AFL 09-39

TO: General Acute Care Hospitals

SUBJECT: H1N1 Response

Authority:
Government Code (GC) §8558
California Code of Regulations (CCR), Title 22, §70129, §70217, §70805, §70809

Background:
As the ongoing California Department of Public Health (CDPH) H1N1 response continues, CDPH Licensing and Certification Program (L&C) continues to provide information to licensed health care facilities. This All Facilities Letter (AFL) outlines requirements during this potential health care emergency. See Sections I through VI below for more information.

I. Rescission of AFL 09-19's Reporting Requirements:

AFL 09-19 stated, "All cases of confirmed or probable H1N1 Flu infection in hospitalized patients must be reported within one working day to the local health department and also to the CDPH L&C District Office. Patients with severe respiratory illness who have H1N1 Flu infection as part of their differential diagnosis should also be reported."

This AFL rescinds the above instruction to hospitals to report occurrences of H1N1 to their L&C District Office. The above rescission does not apply to unusual occurrences which must continue to be reported in compliance with regulations.

II. Tent Use:

Approval to set up a tent is required by California Code of Regulations Title 22 (22 CCR), §70805, which states that, "Spaces approved for specific uses at the time of licensure shall not be converted to other uses without the written approval of the Department." Use of hospital property for tents constitutes a conversion of space. This means that hospitals must obtain CDPH's written approval for tent use. Approval of tents will not be provided unless the hospital has obtained written approval from the local fire authority for tent use.

In the absence of any specific suspension of statute or regulation by Governor's Executive Order, tents will be approved for use only as waiting rooms, to conduct triage and Medical Screening Exams, to provide basic first-aid, and outpatient treatment that meets all applicable rules and regulations. Any other use may require a program flex. A form has been provided that can be used to submit a program flex request to provide services in tents beyond those described above. See Section VI below.

Non-declared emergency tent use approval:
CDPH L&C has been addressing high patient volume at individual hospital Emergency Departments (EDs). This has included approving the use of tents to meet the increased demand for medical care.

To receive approval for tent use, hospitals must contact their L&C District Office (DO), explain their situation, justify their use of tents, and obtain tent use approval.

Additionally, L&C has determined that the present threat of widespread H1N1 infection could cause many hospitals to have a need to convert space almost simultaneously. This determination has resulted in the development of an alternative form for L&C's tent use approval during a declared emergency, in addition to this case-by-case approval process. See the following for this process.

Tent Use Approval during a declared emergency:
This AFL is L&C's written approval of tent use as long as the necessary criteria, provided below, have been met. This alternative approval process for the use of tents is only for the current H1N1 response and only during the time of a declared emergency, specifically when:

- The Governor has declared an emergency, as defined in GC Section §8558, for the hospital's geographical area and stated that health care surge exists,

OR

- An authorized local official, such as a local health officer or other appropriate designee, has declared a local emergency, as defined in GC Section §8558, for the hospital's geographical area and stated that health care surge exists,

AND

- Hospitals have reported setting up and using a tent to their local L&C District Office (A form has been provided that can be used to notify L&C. See Section VI below.)

Hospitals should expect L&C to periodically contact them to get status reports on their use of a tent. When a declared emergency that meets the above criteria is over, there is no further approval for the use of tents for patient care. Please notify

your local L&C District Office when the use of the tent is discontinued and the tent is taken down.

III. Patient Accommodations:

According to 22 CCR, §70809(a), "No hospital shall have more patients or beds set up for overnight use by patients than the approved licensed bed capacity except in the case of a justified emergency when temporary permission may be granted by the Director or his designee."

Additionally, pursuant to 22 CCR §70809(c), "Patients shall not be housed in areas which have not been approved by the Department for patient housing and which have not been granted a fire clearance by the State Fire Marshal, except as provided in paragraph (a) above."

Hospitals must request and receive L&C approval to use more beds than their licensed capacity. This approval process is distinct from the program flexibility approval process as described in 22 CCR §70129. The services provided within the expanded capacity must be in compliance with all applicable laws and regulations at all times. A form has been provided that can be used to submit requests for space accommodation approval. See Section VI below.

IV. Space Conversion Approval:

22 CCR, §70805 requires, "Spaces approved for specific uses at the time of licensure shall not be converted to other uses without the written approval of the Department." Use of hospital property for any purpose other than that approved at the time of licensure, therefore, constitutes a conversion of space and requires L&C approval.

The approval process to convert space is distinct from the program flexibility approval process as described at 22 CCR §70129. The services provided within the expanded capacity must be in compliance with all applicable laws and regulations at all times. A form has been provided that can be used to submit requests for space conversion approval, see Section VI below.

V. Nurse to Patient Ratio Requirements:

L&C has no mechanism for "suspending" or "waiving" regulations which represent the minimum standards providers are required to meet at all times. The nurse to patient ratios, at 22 CCR §70217, are the same as all other regulations. If a hospital has an alternative means of meeting the intent of the regulations, then the hospital can request program flexibility in accordance with 22 CCR §70129, and L&C will give the request all due consideration. Please submit your request using the form provided at Section VI below.

VI. Request Forms:

A form to use in submitting H1N1 requests for L&C approvals, as referenced above, is provided at www.cdph.ca.gov/programs/Pages/LnC.aspx

If you have questions about this AFL, please contact your local L&C District Office.

Sincerely,

Original Signed by Kathleen Billingsley, R.N.

Kathleen Billingsley, R.N.
Deputy Director
Center for Health Care Quality

Print Form

Licensing and Certification Program
Temporary Permission for Program Flexibility

This form is to be used ONLY for program flexibility requests during the H1N1 influenza pandemic when hospitals temporarily need to comply with licensing requirements by using alternative concepts, methods, procedures, techniques, equipment, or personnel due to disease outbreak (H1N1).

Hospitals are required to submit a program flexibility request to the California Department of Public Health (CDPH), Licensing & Certification (L&C) Program through their local district office for written approval. This form is a mechanism to expedite the request and approval process in emergency situations.

Instructions: Complete one form for each request. Fax the completed form to the appropriate district office listed on page 3.

Facility Name	Request Date
License Number	Facility Phone Number (Format: 999999999, no dashes/spaces)
Facility Address	Facility Fax Number (Format: 9999999999, no dashes/spaces)
City / State (CA) / Zip Code (Format:99999)	Contact Person Name

Notification of Emergency Tent Use

☐ **Emergency Tent Use**

Hospital has obtained written approval from the local fire authority for tent use, **and**

a. The Governor has declared an emergency, as defined in GC Section §8558, for the hospital's geographical area and stated that health care surge exists, **or**

b. An authorized local official, such as a local health officer or other appropriate designee, has declared an local emergency, as defined in GC Section §8558, for the hospital's geographical area and stated that health care surge exists.

Approval Request

Select the request (Check all that apply):

☐ Tent Use (High Patient Volume)
☐ Space Conversion (Other Than Tent Use)
☐ Bed Use
☐ Over Bedding

Program Flex Request

What regulation are you requesting program flexibility for?

For CDPH Use Only:
L&C District Office Staff Signature: Date:
Comments:

Facility Name	License Number	Request Date

Briefly summarize your request for program flexibility:

Attach additional documentation as needed; include facility name and license number on each additional page.

Bakersfield District Office
1200 Discovery Plaza, Suite 120
Bakersfield, CA 93309
Phone: (661) 336-0543
Toll Free: (866) 222-1903
FAX: (661) 336-0529

Chico District Office
126 Mission Ranch Boulevard
Chico, CA 95926
Phone: (530) 895-6711
Toll Free: (800) 554-0350
FAX: (530) 895-6723

Daly City District Office
350 90th Street, 2nd Floor
Daly City, CA 94015
Phone: (650) 301-9971
Toll Free: (800) 554-0353
FAX: (650) 301-9970

East Bay District Office
850 Marina Bay Parkway, Building P, 1st Floor
Richmond, CA 94804-6403
Phone: (510) 620-3900
Toll Free: (866) 247-9100
Toll Free: (800) 554-0352
FAX: (510) 620-3924
FAX: (510) 620-5820

Fresno District Office
285 West Bullard, Suite 101
Fresno, CA 93704
Phone: (559) 437-1500
Toll Free: (800) 554-0351
FAX: (559) 437-1555

Los Angeles District Offices correspondence:
5555 Ferguson Drive, Suite 320
City of Commerce, CA 90022
Phone: (323) 869-8206
Toll Free: (800) 228-1019
Fax: (323) 890-8753

Orange County District Office
2150 Towne Centre Place, Suite 210
Anaheim, CA 92806
Phone: (714) 456-0630
Toll Free: (800) 228-5234
FAX: (714) 456-0643

Redwood Coast/Santa Rosa District Office
2170 Northpoint Parkway
Santa Rosa, CA 95407
Phone: (707) 576-6775
Toll Free: (866) 784-0703
Fax: (707) 570-3763

Riverside District Office
625 East Carnegie Drive, Suite 280
San Bernardino, CA 92408
Phone: (909) 388-7170
Toll Free: (888) 354-9203
FAX: (909) 388-7174

Sacramento District Office
3901 Lennane Drive, Suite 210
Sacramento, CA 95834
Phone: (916) 263-5800
Toll Free: (800) 554-0354
FAX: (916) 263-5840

San Bernardino District Office
464 West Fourth Street, Suite 529
San Bernardino, CA 92401
Phone: (909) 383-4777
Toll Free: (800) 344-2896
FAX: (909) 888-2315

San Diego North District Office
7575 Metropolitan Drive, Suite 104
San Diego, CA 92108-4402
Phone: (619) 278-3700
Toll Free: (800) 824-0613
FAX: (619) 278-3725

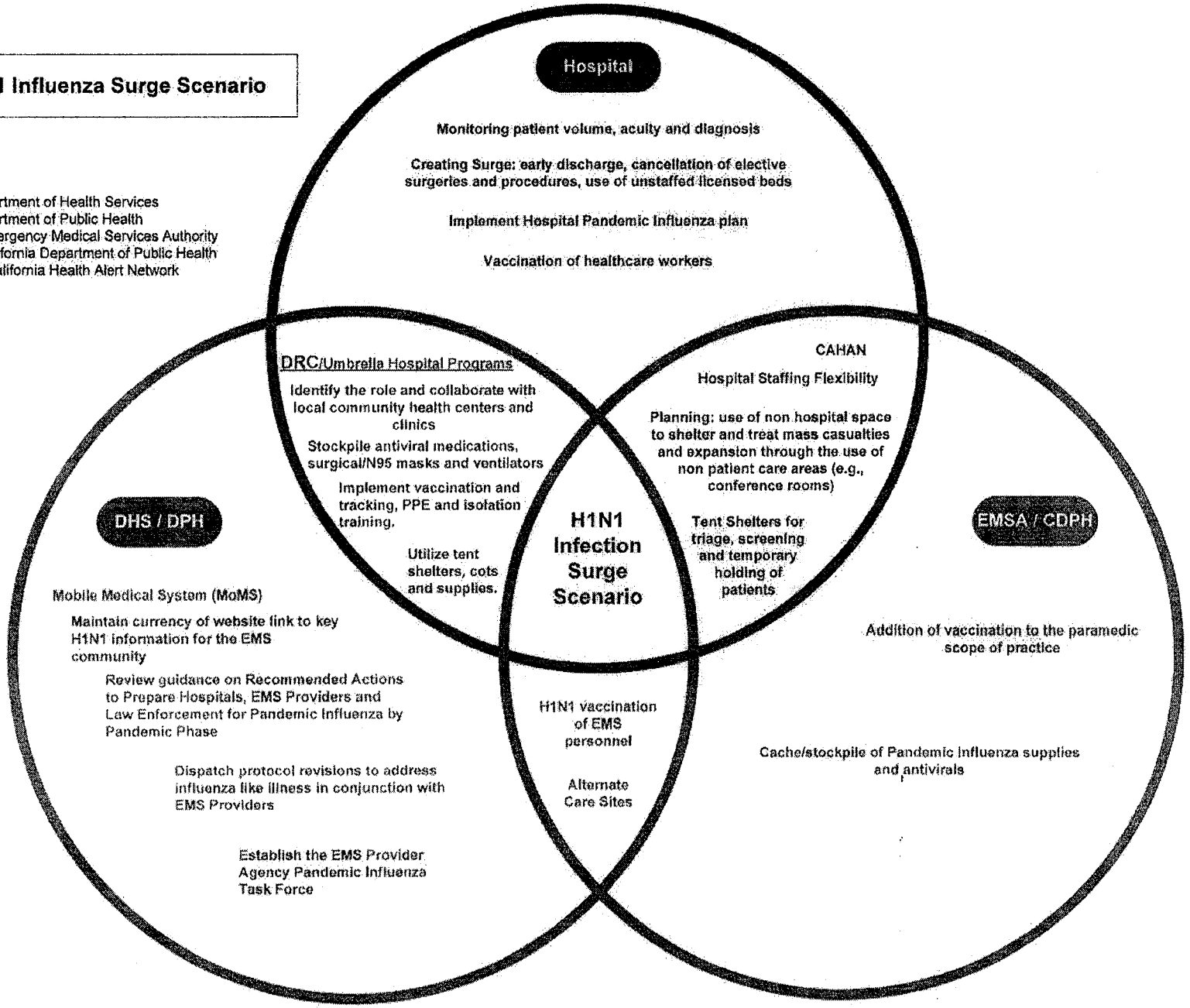
San Diego South District Office
7575 Metropolitan Drive, Suite 211
San Diego, CA 92108-4402
Phone: (619) 688-6190
Toll Free: (866) 706-0759
FAX: (619) 688-6444

San Jose District Office
100 Paseo de San Antonio, Suite 235
San Jose, CA 95113
Phone: (408) 277-1784
Toll Free: (800) 554-0348
FAX: (408) 277-1032

Ventura District Office
1889 North Rice Avenue, Suite 200
Oxnard, CA 93030
Phone: (805) 604-2926
Toll Free: (800) 547-8267
FAX: (805) 604-2997

H1N1 Influenza Surge Scenario

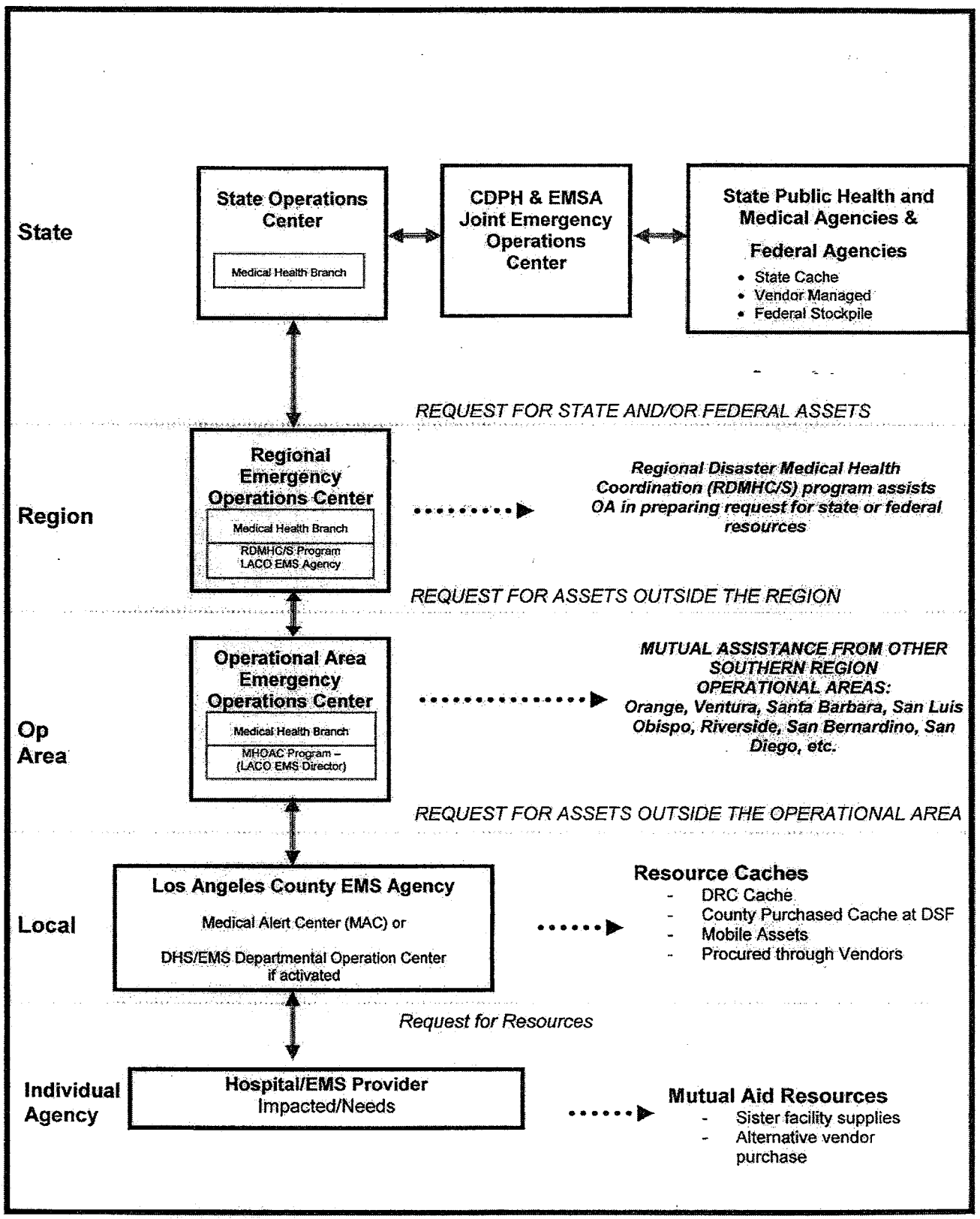
LEGEND:
DHS: Department of Health Services
DPH: Department of Public Health
EMSA: Emergency Medical Services Authority
CDPH: California Department of Public Health
CAHAN: California Health Alert Network



Attachment III

RESOURCE REQUEST FLOW CHART

Attachment IV



◄• • • • • • • • • • • • • • ► Activity to fulfill resource request. Actions start at bottom and move up each level until need met

◄═══════► Information flow during emergency system activation and resource coordination

Attachment V

Health Services
LOS ANGELES COUNTY

November 3, 2009

TO: Each Supervisor

FROM: John F. Schunhoff, Ph.D.
Interim Director

SUBJECT: **SEASONAL FLU/H1N1 PREPAREDNESS**

John F. Schunhoff, Ph.D.
Interim Director

Robert G. Splawn, M.D.
Interim Chief Medical Officer

313 N. Figueroa Street, Room 912
Los Angeles, CA 90012

Tel: (213) 240-8101
Fax: (213) 481-0503

www.dhs.lacounty.gov

To improve health through leadership, service and education.

The Department of Health Services (DHS) is actively preparing to address any potential acute and unpredictable health threats posed by the H1N1 or seasonal flu.

DHS has developed a system-wide Flu Task Force which is currently meeting on a weekly basis. The committee is comprised of clinical and administrative staff from key areas of infection control, employee health services, pharmacy affairs, inpatient services and ambulatory care. The membership is charged with identifying and implementing evidence-based best practices that will serve to mitigate against a potentially severe flu season.

Key areas of action planning include updating and reviewing all hospital Flu and Operational Area Plans, DHS employee vaccination policies and status, pharmacy procurement of antivirals, vaccine distribution and prioritization, Personal Protective Equipment (masks) policies, antiviral and ventilator stockpiles, coordination efforts with the Department of Public Health and the Emergency Medical Services Agency and updating DHS communication plans and protocols.

HOSPITAL PLANS

DHS is updating and enhancing its enterprise-wide response plans based on this year's impact projections for H1N1 and the seasonal flu for Los Angeles County. The plans are being revised to reflect the most relevant Federal, State, and Department of Public Health (DPH) recommendations for preparedness. Each hospital's network (the Multispecialty Ambulatory Care Centers, the Comprehensive Health Centers and Health Centers) has flu plans detailing the various policies, processes, and procedures for a coordinated response.

The updated plans cover essential areas such as: hand hygiene/cough etiquette, patient/employee vaccination policies, influenza patient management, staffing/human resource preparation, infection control policies and procedures, ensuring adequate medical equipment and supplies, data collection for influenza-like illnesses, tracking and reporting, active screening guidelines at facility entrances for employees, patients and visitors, mask-wearing policies, visitor restrictions and internal and external communication plans.

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DHS EMPLOYEE VACCINATIONS FOR H1N1 AND SEASONAL FLU

Vaccination of healthcare workers (HCWs) is being coordinated by each hospital network's Employee Health Services (EHS) Unit. Mandatory vaccination of HCWs is not required in the State of California. However, employees must sign a declination form and indicate the reason for not taking the vaccine. DHS has developed a standard declination form that is used by all DHS facilities. EHS is increasing efforts to encourage all HCWs to get vaccinated, providing vaccines at staff meetings, conducting in-house flu clinics, and making rounds on different units utilizing flu carts. An Influenza report has been developed and is submitted weekly to the Chief Medical Officer to monitor the effectiveness of staff outreach.

Attachment 1 outlines the number of employees and doses administered of seasonal and H1N1 vaccine in each hospital cluster.

PHARMACY SERVICES VACCINE AND ANTIVIRAL PURCHASE AND DISTRIBUTION

The Office of Pharmacy Affairs is actively ensuring that sufficient supplies of the seasonal flu vaccine and the H1N1 vaccine are secured for DHS. Sixty thousand doses of seasonal flu vaccine were ordered with approximately 85% received as of October 20, 2009.

The initial estimate of H1N1 vaccine projected to be available has been reduced twice by the Federal Government. As of October 30, 2009; DHS has received 18,200 (16%) doses of H1N1 vaccine, out of 111,000 ordered. In addition, another 65,000 doses were ordered on October 30, 2009. DHS follows the Centers for Disease Control and Prevention (CDC) guidelines for risk group prioritization. All DHS facilities have provided information on the total number of employees for whom vaccination is recommended, and have prioritized high risk employees based on the availability of vaccine, the CDC guidelines and patient care needs. To ensure an adequate health care workforce to serve DHS patients, the department is focusing on vaccinating targeted patient care employees first. However, some high risk patients are also being provided the vaccine as available and clinically indicated.

The Office of Pharmacy Affairs has also increased onsite pharmacy orders for Oseltamivir (Tamiflu), an oral anti-viral drug utilized for patients who require treatment for the H1N1 flu. DHS' Core Pharmacy and Therapeutics Committee has approved a prior authorization form for providers requesting oseltamivir treatment to ensure that the limited doses available of this agent are utilized primarily in high risk patients or employees exposed to an H1N1 case.

OPERATIONAL AREA PLANNING

The Emergency Medical Services (EMS) Agency, the division responsible for overseeing medical response and coordinating the federally funded Hospital Preparedness Program, has been working with public/private hospitals, clinics and emergency medical services provider agencies (fire departments and ambulance companies) to ensure seasonal flu planning includes all partner organizations. Planning activities have focused on access to key resources such as masks, antivirals and ventilators as well as medical surge planning. The medical surge planning is done by each individual hospital and integrated under the Disaster Resource Center (DRC) program which divides the County into ten geographical regions and assigns one or two hospitals to coordinate preparedness activities with the surrounding healthcare providers. The Hospital Association of Southern California (HASC) is another key partner included in these planning activities that assists us in coordinating with hospitals in its organization.

In 2007, Pandemic Influenza guidance documents were developed and distributed to hospitals and EMS provider agencies. These documents are being reviewed and will be updated based on the emergence of the H1N1 virus.

Mask and Antiviral Stockpile

Federal grants managed by EMS and DPH have funded the purchase of over one million N95 masks and over two million surgical/procedure masks that have been stockpiled for the public/private hospitals, clinics and emergency medical services providers. A stockpile of antivirals was also established.

EMS has developed a distribution methodology for hospitals, public/private clinics and emergency medical services provider agencies. In May 2009, fifty percent of the antiviral stockpile was distributed to hospitals to ensure a base amount available to treat hospitalized patients. DPH also received twenty-five percent of Los Angeles County's distribution of antivirals from the Strategic National Stockpile.

In July 2009, additional funding specific to supporting seasonal flu preparedness and response was awarded to the EMS Agency. This funding will support vaccination efforts and medical surge activities at hospitals, public/private clinics and to purchase additional masks and antivirals.

Ventilator Stockpile

The Hospital Preparedness Program, the Public Health Emergency Preparedness Program and Homeland Security Grant Program provided funding for the 13 hospitals designated as DRCs to purchase 25 ventilators each and four non-DRC Trauma Centers to purchase five ventilators each to increase the overall supply of ventilators in the County. Additionally, the EMS Agency has a vendor-managed cache of 113 ventilators that would be made available if needed. The State and Federal government also have stockpiles of ventilators and these could be requested to support the medical response in addition to Los Angeles County's existing resources.

COMMUNICATION

DHS facilities have begun implementing their pandemic/risk communication plans to get accurate and updated information on H1N1 to patients and visitors. Respiratory hygiene and H1N1-specific signage is being placed in key hospital and clinic traffic areas, and additional signage needs for special flu clinics and triage areas are being assessed and developed. Multi-lingual fact sheets developed by DPH are being disseminated to staff and visitors and posted on the DHS website, and staff forums are being planned at all DHS facilities. Additionally, facility Public Information Officers are participating in regular conference calls with other statewide public hospital communications staff on messaging strategy and best practices.

H1N1 activity and vaccination updates from the DHS Chief Medical Officer are being distributed to department staff on a regular basis, in addition to DPH news updates. DHS is currently including H1N1 messaging on system-wide information/appointment phone lines through a link to County 211. The facilities are also broadcasting H1N1 educational videos in patient waiting areas. To effectively prepare its experts to discuss flu activity and prevention, the department also conducted two media training sessions the week of October 19 for key facility-based clinical spokespersons.

DEPARTMENT OF PUBLIC HEALTH COORDINATION

DHS is also assisting DPH's efforts by asking health facilities for available nurses to work in the Points of Distribution (PODs). To date, about 200 DHS nursing staff have signed up to assist DPH. EMS staff are also deployed to DPH's Departmental Operations Center to ensure coordination in the H1N1 response, particularly connectivity to hospitals with emergency rooms and paramedic services.

If you have any questions or need additional information please contact Robert Splawn, Interim Chief Medical Officer at (213) 240-8116.

JFS:RS:pm

Attachment

c: Chief Executive Officer
Acting County Counsel
Executive Officer, Board of Supervisors
Director and Health Officer, Department of Public Health

DHS Flu Vaccination Status for Healthcare Workers - All Facilities
Seasonal Flu and H1N1 Vaccine
Date: 2-Nov-09

		Seasonal Flu Vaccine						H1N1 Vaccine					
		County Employees-Target Number	# vaccinated	# declined vaccine	Contract - Volunteer-Student Staff-Target Number	# vaccinated	# declined vaccine	County Employees-Target Number	# vaccinated	# declined vaccine	Contract - Volunteer-Student Staff-Target Number	# vaccinated	# declined vaccine
Northeast	LAC+USC Med Center Roybal CHC Hudson CHC El Monte CHC	8,305	3,125	1,794	2,189	1,223	232	8,305	1,190	108	2,189	367	0
Metrocare	Harbor/UCLA Med Center Long Beach CHC MLK Humphrey CHC	5,130	2,443	229	1,477	551	29	5,130	1,234	23	1,477	175	1
Valley Care	Olive View Med Center Mid-Valley CHC/ San Fernando HC High Desert HS	3,115	1,353	0	2,843	465	0	3,115	899	0	2,843	260	0
RLA	Rancho Los Amigos NRC	1,429	779	492	600	211	9	1,429	181	625	600	0	0
	DHS Systemwide Total	17,979	7,700	2,515	7,109	2,450	270	17,979	3,504	756	7,109	802	1